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The Revealing Case of Indiana

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Patrick O'Donoghue

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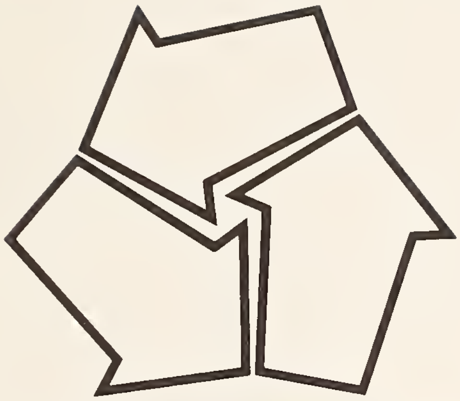

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Preface

This summary is an adjunct to the report entitled Controlling Hospital Costs: The Revealing Case of Indiana. The latter is the main report in the Spectrum Research study which analyzes the effects of the Indiana Prospective Rate Setting Program. Like the summary, it is written by me and published by Policy Center, an organization associated with Spectrum Research.

Most of the financial support for the Indiana study was provided by a DHEW contract. The main report is a product specified in the contract, although its publication was financed by Policy Center. While the summary is drawn from the main report, its preparation was not undertaken pursuant to the contract, but rather was supported by Policy Center.

In a concise and focused manner, the summary discusses the primary study findings and their policy implications. It has two functions. One is to serve as an introduction for those intending to read all or substantial parts of the main report. The other is to convey the central study results to those not necessarily planning to review the main report.

As noted, the Indiana study was largely supported by DHEW. It benefited from the strong cooperation of hospitals, Blue Cross plans, and hospital associations in Indiana and the control states; and it received valuable contributions from many individuals, especially my principal coworkers -- Tonie Gatch, Melissa Culverwell, and Nancy Shanks. Nonetheless, the study conclusions and results remain my responsibility, and should therefore not be attributed to DHEW or other organizations.

Patrick O'Donoghue, MD

Denver, Colorado
October 1978

Summary

Widespread consternation about hospital costs characterizes American life at the present time. At the most basic level two conditions are responsible. First, the hospital industry is large. In 1975 this industry alone, excluding physician services, consumed more than $50 billion, or about 3.5% of the gross national product. Second, during the last quarter century hospital costs increased much more rapidly than consumer prices as a whole. Between 1950 and 1975 hospital costs rose by 817% compared to a 124% increase in the Consumer Price Index.

Almost coincident with the rise in hospital cost inflation, analysts and policymakers have pointed to a factor which may strongly contribute to such inflation. It is the way hospitals are paid. In the early 1950s most hospitals were paid on the basis of charges for specific services. Blue Cross plans and other insurers seldom reviewed these charges and thus exerted little downward pressure on hospital costs. This approach of paying charges without review became steadily less tenable as insurance coverage expanded, thereby decreasing consumers' concern about the size of their hospital bills.

During the late 1950s and the 1960s there was a shift toward another hospital payment approach -- a movement sharply accentuated by the advent of the Medicare program in 1966. Termed retrospective reimbursement, this approach entails advancing hospitals interim payments for cash flow purposes and reaching final settlement on the basis of actual costs incurred during the preceding reporting period.

Compared to paying hospital charges without review, this approach offers certain advantages, such as the elimination of large paper profits and the exclusion of certain types of costs. However, retrospective reimbursement has a major and perhaps fatal defect. It offers hospitals no incentive to restrain costs. As long as a cost can be categorized as allowable after the fact by the hospital, it is covered by the third-party payer.

Because of this defect and the persistence of hospital cost inflation, emphasis has been placed on a third approach to hospital payment under which hospitals are paid on the basis of rates established in advance by the rate setting program. Compared to retrospective reimbursement, this approach of prospective rate setting potentially confers important advantages by virtue of two fundamental characteristics.

First, the financial incentives are reversed. At a minimum this approach provides an incentive for the hospital not to exceed its projected budget which forms the basis for its prospective rates. Second, under prospective rate setting the hospital budget and thus planned hospital actions are reviewed in advance. As a consequence, a much wider array of options are open to the program and the hospital.

During the 1970s public favor has been increasingly bestowed on prospective rate setting. Programs based on this approach have been established in a number of states. However, despite the movement toward prospective rate setting, there is little sound analysis indicating that this approach realizes its potential advantages. This study was designed to partially fill this gap between increasing reliance on prospective rate setting and the dearth of systematic analysis demonstrating its effectiveness.

It achieves this goal by conducting a comprehensive evaluation of a major prospective rate setting system -- the Indiana program. This evaluation constitutes a definitive test of the general hypothesis implied in recent policy developments:

> Prospective rate setting can reduce hospital cost inflation without adversely affecting the effectiveness of hospital care and without incurring inordinate expenses.

Further, since the Indiana program represents a fundamental approach to prospective rate setting, the study furnishes evidence indicating whether this approach is likely to succeed. Equally significant, it illuminates important issues germane to the process of controlling hospital costs. The study findings therefore provide the basis for drawing conclusions generic to prospective rate setting and other forms of hospital cost control.

The Indiana Program

The Indiana prospective rate setting system was established in 1960 by Indiana Blue Cross (IBC) and the Indiana Hospital Association (IHA). Since its inception its primary purpose has been to control hospital costs by increasing the efficiency of hospital care. Throughout the program's history this purpose has been interpreted broadly. The Indiana system emphasizes not only cost reduction, but also the provision of high quality care.

Participation in the Indiana program is a requirement of hospitals' contracts with Indiana Blue Cross, the largest third-party payer and the only Blue Cross plan in the state. The prospective rates established by the Indiana program apply directly to Blue Cross patients. In accord with program guidelines, Indiana hospitals charge the same rates to self-paying patients and to individuals covered by commercial insurers. The Medicare and Medicaid programs have chosen not to pay hospitals according to prospectively determined rates in Indiana, but rather to utilize their customary retrospective reimbursement approach.

The Indiana program thus encompasses all but publicly insured hospital patients in Indiana. That is, its scope directly extends to approximately 75% of Indiana hospital patients who account for more than 60% of the state's hospital expenditures.

The organization administering the program is Indiana Blue Cross. It has established a special body, the Rate Review Committee (RRC), whose function is to review and approve hospital budgets and charges. The Rate Review Committee now has 20 members, who serve on a part-time basis. Six are hospital managers (termed the provider members), while the remaining 14 (termed the public members) are drawn from a wide variety of backgrounds, including accounting, medicine, banking, and industry management. As at present, the Committee has always had a majority of public members.

Indiana Blue Cross also provides staff support for the program. The primary unit involved is the Rate Review Staff (RRS), whose members are full-time IBC employees. There are presently eight RRS members, most of whom have accounting expertise.

Another important element of the Indiana system is the involvement of health planning agencies. Since 1965 prior planning agency approval of capital projects has been required by the Indiana program in order for a hospital to include within its rate structure depreciation, interest, and other capital expenses arising from such projects.

Working closely with Indiana Blue Cross, the Indiana Hospital Association has been involved in the development and operation of the Indiana program since 1960. Both the executive officer and chairman of IHA serve as ex officio members of the Rate Review Committee. Largely through its Council on Finance and Reimbursement, IHA plays a major role in devising the program's guidelines and data requirements. Illustrating this point, the Indiana Rate Review Manual is a joint effort of IHA and IBC.

The Indiana system has the solid support of individual hospitals, as evidenced by the fact that the program has never been sued by a hospital. In responding to the Project Survey, 84% of Indiana hospitals indicated that the Indiana program is a good system and should be continued in its present form. Ten percent thought it should be replaced with another type of prospective rate setting program, while only 4% preferred a retrospective reimbursement system.

Hospitals must submit their formal rate requests to the Indiana program at least 45 days prior to an RRC meeting. After review by the RRS, the request is considered by the Rate Review Committee which must reach one of the following five decisions: complete approval; partial approval; conditional approval (the request is granted but subject to periodic evaluation); rejection; or deferral.

Like all prospective rate setting systems, the Indiana program attempts to control hospital cost inflation by restraining the growth of hospital revenues. Unlike some systems, the unit of payment used by the Indiana program to accomplish this objective is approved charges for specific services, with the room rate being the most important single charge. For this reason the Indiana program is often described as a "controlled charges" system -- a characterization which is partially deceiving. While many individual statistics and charges are reviewed, attention centers on the aggregate percentage increase in a hospital's rates, which is calculated directly from the projected hospital budget. The Indiana program is thus more accurately characterized as a total budget review system.

Flexibility and informality characterize the Indiana system. While the program employs written guidelines, they are not detailed strictures. Rather, they are general rules designed to be interpreted flexibly. Rate Review Committee meetings are not sharply adversarial proceedings nor do they otherwise have the tone of a public hearing. Further, unlike some regulatory systems, the Indiana program has not become enmeshed in legalistic process. Briefs written in legal terms are rare and lawyers are infrequently involved in the system's activities.

The Indiana program has at times been described as a voluntary system. This characterization is not in fact correct. Adherence to the program's rates is essentially compulsory for Indiana hospitals. However, the Indiana program is a system established and operated by the private sector. The extent of government involvement is minimal. The Medicare program has made a point of not participating in the Indiana system. While the relationship between the latter and the state government is stronger now than it was earlier, the Indiana program nonetheless remains a predominantly private system.

Methodology

This study determines the effects of the Indiana program by comparing Indiana and control hospitals. The latter were selected from four states -- Michigan, Illinois, Minnesota, and Iowa. None of these states had a prospective rate setting program during the main study years. Each is located in the Midwest, and all are similar to Indiana in terms of important statewide characteristics. A computerized matching procedure was employed to select the specific control hospitals. As a consequence, except for hospital payment/planning systems, the environments of Indiana and control hospitals are similar.

Most study results are based on regression analysis -- a powerful technique since it takes into account the effects of other variables in determining the Indiana program's influence. For example, the total cost regression analyses indicate the Indiana system's impact on hospital costs, taking into account the effects of such variables as county income level. All regression results described in this report as showing that the Indiana system increases or decreases a variable are statistically significant.

Other study findings are derived from two sets of site visits -- one to a randomly-selected subsample of Indiana hospitals and the other to individuals involved in the Indiana program. The advantage of the first set is that its sample is not biased; its disadvantage is that it does not secure the insights of those closely associated with the program. The second set has the reverse strong and weak points. Together they constitute a strong information-gathering approach.

The regression results are drawn from the main study time period which is the six-year span from 1968 through 1973. Time trend analyses broaden these findings by comparing the average costs of Indiana and control hospitals from 1958 through 1976. The site visit findings are not based on any single year, but rather reflect the Indiana system's continuing influence on hospital behavior. The principal data sources used in the study were Medicare Cost Reports, the Project Survey, the American Hospital Association Survey, Bureau of Census data, and the data base of the Commission on Professional and Hospital Activities.

Impact in Indiana

Influence on Hospital Costs. The regression analyses show that the Indiana program achieves its foremost objective: It substantially reduces total hospital cost. The program's effect on cost rises steadily during the main study years. In 1973 the Indiana system reduced hospital costs by 10%. That is, Indiana hospital costs were 10% lower in that year than they would have been if the program had not existed. The program's percentage impact in 1968 is lower, -4%. Its percentage influence in the intervening years is consistent with these results, equalling -5% in 1970 and -10% in 1972.

The regression results also show that the Indiana system's influence on cost is sizeable in dollar terms. In 1968 the program lowered hospital expenses by $16 per case (i.e., Indiana hospital costs were lower by that amount than they would have been in the program's absence). Like its percentage impact, but to an even greater extent, the program's dollar influence increases during the main study time period, equalling -$29 and -$69 per case in 1970 and 1972 respectively. In 1973 it is higher yet: In that year the Indiana program decreased hospital costs by $80 per case.

The Indiana system's influence on hospital costs during the main study years is summarized in the following table. The first column in the table shows the program's dollar impact on total cost (i.e., cost per case). The second column indicates the number of inpatient cases treated by Indiana hospitals. The third column displays the total hospital cost savings produced by the program.

HOSPITAL COST SAVINGS OF THE INDIANA PROGRAM

	Impact on Cost per Case	Indiana Hospital Cases	Hospital Cost Savings
1968	-$16	670,000	$10,720,000
1969	-$23	688,000	$15,824,000
1970	-$29	712,000	$20,648,000
1971	-$49	733,000	$35,917,000
1972	-$69	747,000	$51,543,000
1973	-$80	777,000	$62,120,000

As shown above, the Indiana program's hospital cost savings increase from about $11 million in 1968 to about $62 million in 1973. During the main study years these savings total $196,812,000, or almost $200 million.

The time trend findings extend the regression results. They show that the Indiana system's effect on cost has progressively increased from the early 1960s through 1976. The program's hospital cost savings cannot be determined as precisely from the time trend findings as from the regression results. Nonetheless, the former can be used to estimate the probable range of the program's cost savings both before and after the main study time period.

Based on this approach, it is likely that the hospital cost savings of the Indiana system average between $5 million and $9 million per year during the six-year span from 1962 through 1967. The program's average annual cost savings during the three years from 1974 through 1976 are much larger, equalling between $71 million and $120 million. In 1976, the last time trend analysis year, the cost savings of the Indiana program range between $80 million and $135 million, clearly exceeding its cost savings during any of the main study years.

Pathways of the Program's Cost Influence. The regression findings indicate that the Indiana program's dominant effect is on the hospital's use of labor resources. It impacts total hospital cost primarily by reducing labor cost. The program also affects the hospital's use of supplies and services, and reduces total cost by decreasing supply/ service cost. It has little influence on the hospital's utilization of capital resources, and does not decrease total cost through this mechanism in any study year.

The Indiana system's influence on the labor sector is pervasive. It reduces both wage level and skill mix; it increases individual productivity. As a result of these effects, the program increases labor productivity and decreases average salary, thereby reducing costs through both variables.

Despite its well-established planning component, the Indiana program has only a limited impact on the capital sector. Its influence on capital expenditures is insignificant; its impact on capital productivity is positive but much weaker than its influence on labor productivity.

The Indiana system reduces all three departmental costs -- nursing cost, ancillary cost, and administrative/hotel cost. No major department is thus refractory to its influence. Consistent with its dominant effect on labor cost, the departmental cost most strongly impacted by the Indiana program is nursing cost.

Side Effects. Critically important is the regression finding that the Indiana program's influence on hospital quality is insignificant. Further, the program does not impact the types of services provided by Indiana hospitals, since its effects on both specialized service mix and basic service mix are insignificant.

The regression results also show that the Indiana program has an insignificant influence on all three case intensity variables -- case mix, case severity, and elective surgery. Similarly, it has an insignificant impact on utilization practices. Reflecting these findings, the Indiana system has an insignificant influence on length of stay, a fundamental measure of hospital utilization.

There is thus no evidence that the Indiana system damages the effectiveness of hospital care -- a possibly fatal side effect if it were present. The cost reduction achieved by the program is consequently a pure efficiency effect. That is, costs are lower, but the nature of hospital output is unchanged. The same kinds of patients are given the same type and quality of care in Indiana hospitals as in control hospitals, but at a lower price.

The regression findings also show that the Indiana system has not substantially depleted the financial resources of hospitals, another potentially important side effect. The central findings here are that the program's effects on both net worth and working capital are insignificant.

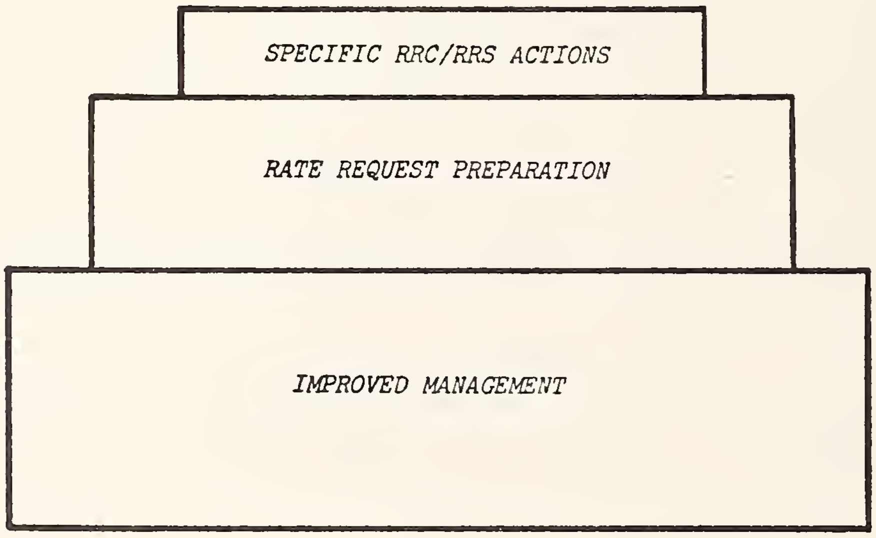
Influence on Hospital Management. The site visit findings indicate that the Indiana program impacts hospitals by influencing the actions of the administrative staff in general and the administrator in particular. The program achieves its effects partially through financial incentives, but primarily through professional incentives.

The Indiana system is directed toward the management of the hospital; its major focus is on the justifiability of costs from a management perspective. Because hospitals feel they have a voice in the program and because the program is regarded as tough and knowledgeable, but still equitable, it is widely respected by Indiana hospitals. As a consequence, through its review procedures the Indiana system is able to reinforce the inherent desire of most administrators to be efficient managers, thereby improving hospital management.

As shown in the figure below, the Indiana system achieves its greatest cost savings by motivating the administrative staff to improve hospital management. Three intertwined elements are responsible for the improvement in management: greater cost consciousness, improved planning and budgeting, and careful decision making based on evaluation of cost tradeoffs. The next largest fraction of the program's cost savings results from the preparation of rate requests by hospitals. The linchpin here is that, unlike a retrospective reimbursement environment, the projected budget is a binding document in Indiana since it is the basis of the hospital's rates.

The great majority of the Indiana system's cost savings are thus attained prior to submission of the rate request. The remainder are due to specific RRS or RRC actions. While such actions are directly responsible for the smallest percentage of the program's cost savings, the possibility that they may occur is the deterrent which enables the Indiana system to achieve larger savings through the other two mechanisms.

ORIGINS OF THE PROGRAM'S COST SAVINGS



Operating Expenses. The Indiana program's total annual expenses are substantial, but not high: $240,000 or about $2,200 per Indiana hospital. These expenses include not only the costs incurred by Indiana Blue Cross, but also those borne by the Indiana Hospital Association and Indiana planning agencies. The costs attributable to the Rate Review Committee are low, equalling $11,000 or less than 5% of the program's total expenses.

From a cost/benefit perspective the key statistic is not the Indiana system's total operating costs, but rather its net operating costs, i.e., the difference between the program's total expenses and the total expenses of similar functions in the control states. Since the latter approximate $164,000, the net operating expenses of the Indiana system are $76,000 or about $700 per hospital.

Net Benefit. The program's net benefit in Indiana is strongly positive -- a result which stems from its negative impact on hospital costs. In 1973, the last main study year, the Indiana system's hospital cost savings approximate $600,000 per institution. In contrast, its net operating expenses are almost trivial, equalling about 1/1,000 of its hospital cost savings.

The Indiana system does not produce undesirable side effects. It does not lower the quality of hospital care nor does it damage the nature of hospital output in other ways. It neither reduces the range of services offered by hospitals nor threatens the financial viability of hospitals.

The Indiana program thus fully satisfies the general hypothesis enunciated earlier for prospective rate setting. It sharply reduces hospital cost inflation; it does not adversely affect the effectiveness of hospital care; and it does not incur inordinate expenses. The study findings therefore indicate that the program is a solid success in Indiana.

Replicability Outside Indiana

Since the Indiana program has a strongly positive net benefit, it is important to determine its replicability in other settings. If it is a phenomenon unique to Indiana, it may well continue to benefit the people of that state, but the implications for other states would be diminished. Conversely, if prospective rate setting systems similar to the Indiana program can function effectively elsewhere, it is likely that they could produce substantial benefits.

Like any regulatory system, the Indiana program has a number of characteristics. Many make marginal contributions, but are not essential to the program's success. Others are sufficiently critical that their elimination would threaten the Indiana program's effectiveness. It is these characteristics which another prospective rate setting system must have to permit generalization of the study findings to that system. In short, it is not necessary to replicate the entire Indiana program to reap its potential benefits. Only the program's essential features need be duplicated.

The following characteristics constitute the minimum set which appear essential to the Indiana system's effectiveness.

- The program's announced and actual purpose is to improve the efficiency of hospital care and to thus control hospital costs.
- Adherence to the program's rates is essentially compulsory for Indiana hospitals.
- The total hospital budget is the binding unit of negotiation.
- Hospitals are paid on the basis of rates established prospectively.
- Sufficient manpower and other resources are devoted to the Indiana system.
- The program emphasizes the justifiability of costs from a management perspective and systematically reinforces this emphasis through its periodic review procedures.
- There is extensive private sector involvement, including both hospitals and third-party payers.
- Substantial and broad-based nonprovider involvement is present.
- The program has the firm support of individual hospitals.
- The Indiana system is flexible and informal, avoiding strict adherence to bureaucratic procedures.

No factors unique to the Indiana program or to Indiana block the program's replicability. The program is not an Alexander the Great phenomenon: No single individual(s) is so crucial that the program would collapse in his or her absence. Indiana as a state is not an outlier in this country. Rather, it lies within the mainstream of the United States in terms of population, physician characteristics, socioeconomic features, and socio-psychological climate.

Operational prospective rate setting systems with all the Indiana program's essential features now exist in at least seven settings: Wisconsin, Southwest Ohio, Rhode Island, Michigan, Florida, Northwest Missouri, and Minnesota. The presence of these systems is concrete evidence of the program's replicability. In addition, prospective rate setting systems similar to the Indiana program but lacking an essential feature are found in Washington, Kansas, and Montana.

It is evident that the replicability of the Indiana system is substantial. This does not imply that an Indiana-type program is feasible in all states. However, the central issue is not whether the program is replicable in all states, but whether it is replicable in most states. The conclusion here is clear: It is eminently possible in most states to set up a prospective rate setting system with the Indiana Program's essential features.

Overall Results

During the last five years prospective rate setting has been increasingly embraced by hospitals, Blue Cross plans, legislatures, and government agencies. The accelerating acceptance of this approach has occurred even though there has been little hard evidence supporting its potential benefits. Had this project found that the Indiana program has little impact, its findings would have cast doubt on the wisdom of relying on prospective rate setting to control hospital costs.

Instead, the study findings show that the Indiana program fulfills the expectations for prospective rate setting which are embodied in the general hypothesis. This result does not imply that all prospective rate setting programs will be successful. Nor does it suggest that most will be effective. Even so, it provides firm support for the thesis that prospective rate setting can effectively control hospital costs.

The Indiana program represents a distinct type of prospective rate setting. Its success in Indiana directly supports the efficacy of this approach to hospital cost control. That is, the study findings can be partially generalized to prospective rate setting systems elsewhere which resemble the Indiana program.

Systems which have all the Indiana program's essential characteristics are now operating in the seven settings identified earlier. The success of the Indiana program implies that these systems may be successful. The study findings do not assure their success, but they furnish hard evidence indicating their potential benefits.

Similarly, if the Indiana program serves as a model for future prospective rate setting systems, the study findings provide a sound rationale for expecting these systems to be successful. Further, the project results furnish less firm but still appreciable support to systems like those described earlier, which resemble the Indiana program but do not have an essential feature.

However, the cloak of this study does not extend to all prospective rate setting programs. The New York system is a case in point. It lacks many essential Indiana program characteristics. The New York program does not establish rates based on total budget review; it does not emphasize the justifiability of costs; it does not have substantial private sector involvement; it does not have solid hospital support; and at a minimum, its theme is not flexibility.

Since the New York system differs markedly from the Indiana program, the study results do not furnish evidence suggestive of the former's success. The same point applies to other systems which are distinctly dissimilar from the Indiana program, such as those in Massachusetts, Connecticut, and New Jersey.

Generic Conclusions

Centrality of the Labor Sector. The crucial importance of the labor sector to prospective rate setting arises from the arithmetic of hospital costs. As an approximation, labor cost, supply/service cost, and capital cost comprise respectively 60%, 33%, and 7% of total hospital cost. The key to hospital cost control is thus the labor sector. If a program decreases labor cost, it is likely to reduce total cost; if it has no influence on labor cost, it is unlikely to significantly lower total cost. Conversely, even if capital cost is cut in half, total cost will fall by only 3.5%.

This does not imply that a program's impact on hospital utilization of capital resources cannot trigger a decrease in hospital cost. It can, but only if the impact affects labor utilization as well as capital utilization. For example, elimination of a hospital service may reduce capital cost if the equipment providing the service is sold, but in most instances it will appreciably reduce total cost only if the employees staffing the service are terminated. Reducing the "duplication of hospital services" in a community will thus significantly lower total costs only if labor costs fall as a result. Similarly, limiting the proliferation of hospital services in the future will curb hospital cost inflation only if labor expenses are significantly constrained by this step.

The centrality of the labor sector means that effective control of hospital costs entails tough trade-offs. There is no magic basket of expensive and unnecessary inputs which can simply be eliminated, thereby decreasing costs without disrupting the community. As the Indiana system's experience shows, hospital costs can be reduced, but at a price. The Indiana program increases labor productivity -- a desirable result from a hospital standpoint, but one perhaps raising unemployment in the community. The program decreases wage level -- another desirable result from a hospital viewpoint, but one probably considered less desirable by hospital employees.

This tension is well illustrated by the major hospital cost containment bills now pending before Congress. All but the Talmadge bill include a provision allowing a pass-through for nonsupervisory wage increases. While understandable politically, this provision is highly questionable from the standpoint of controlling hospital costs.

Efficiency and Effectiveness Gains. Hospital costs can be reduced in two ways. One is by producing the same output at a lower cost. The other is by modifying the nature of output and thereby decreasing cost. The first method entails increasing the efficiency of hospital care, while the second necessitates changing the effectiveness of care. Accordingly, these methods of lowering hospital costs are termed respectively efficiency and effectiveness gains.

The Indiana system's cost impact is a pure efficiency gain -- a result which makes it clear that sizeable cost reductions can be achieved through efficiency gains alone. It is not necessary to change the nature of output to lower hospital costs. They can be substantially decreased simply by operating hospitals more efficiently.

Equally significant, large cost reductions can be attained solely through the actions of the administrative staff. As in other prospective rate setting systems, physicians are only peripherally involved in the Indiana program. Yet, despite this fact, the program still reduces hospital costs. These findings undercut the contention that without substantial physician support the administrative staff is powerless to effect meaningful cost savings. The experience of the Indiana program indicates precisely the reverse.

While greater physician involvement and effectiveness gains are desirable goals, it will prove difficult to achieve these intertwined objectives. At a minimum substantial time will be required. Attaining effectiveness gains entails changing not only the treatment of outlier cases, but also the customary treatment patterns employed by most physicians. Even more important, it is necessary to carefully balance cost and quality considerations. For example, could an effectiveness gain be achieved by sharply reducing the length of stay of heart attack patients? That is, would the cost savings outweigh the quality consequences?

It is thus likely that if a prospective rate setting program seeks both effectiveness and efficiency gains, it will dissipate its energies and achieve neither type of gain. Worse yet, it may reduce the effectiveness of hospital care in unacceptable ways. Hence, it seems clearly inadvisable at the present time for prospective rate setting systems to devote substantial resources to the pursuit of effectiveness gains. Instead, they should concentrate on improving the efficiency of hospital care -- a highly manageable goal as demonstrated by the Indiana program.

Professional versus Financial Incentives. To succeed, any regulatory program must change behavior. It is prohibitively expensive to police all the time. It is imperative to police some of the time. Traffic regulation illustrates these points. Consider the expense of policing each motorist's compliance with a red light, but also consider the red light compliance rate if no citations are issued.

The Indiana program fits this regulatory model. Its major cost savings are achieved primarily by changing hospital behavior. That is, the program stimulates hospitals to improve their efficiency (i.e., to stop at red lights of their own volition). Only a modest fraction of its cost savings results from specific program actions (i.e., its citations). Still, the possibility of such citations is a necessary factor contributing to its effectiveness.

Beyond the simple possession of "policing power," how does the Indiana system produce desirable changes in hospital behavior? A number of factors are involved, but they can be reduced to two main types -- professional incentives and financial incentives. When the prospective rate setting approach was first developed, it was thought that the reversed financial incentives would be sufficient by themselves to change hospital behavior. For example, Public Law 92-603 authorizes the conduct of prospective rate setting projects "to stimulate providers through positive (or negative) financial incentives to use their facilities and personnel more efficiently . . ."

Based on the Indiana program's experience, this thesis is wrong. Financial incentives make significant contributions to the program's impact on hospital behavior, but they are not dominant. Professional incentives are clearly more important. Some such incentives are primarily educational in nature, e.g., the learning experience arising from periodic budget review. Others have an economic basis, e.g., the building of a good reputation to enhance professional advancement. Others are more psychological in nature, e.g., the gut reaction of an administrator that he/she will "simply not defend that kind of an increase to the Rate Review Committee."

The dominance of professional incentives in the Indiana system suggests that other cost control programs may succeed if they rely on these incentives to induce changes in hospital behavior. Conversely, programs which depend heavily on financial incentives are less likely to succeed.

This premise poses a particular difficulty for federal cost control efforts, which tend to be large, uniform, and impersonal. All three characteristics discourage the development of favorable professional incentives. As a consequence, federal initiatives ranging from the Economic Stabilization Program to the Carter proposal to the Talmadge bill generally rely on financial incentives and restrictions. The Indiana program's experience suggests that this almost necessary dependence on financial incentives will make it difficult for these federal initiatives to succeed.

Justifiability versus Allowability. The Indiana program emphasizes whether costs are justifiable from an efficiency perspective, while retrospective reimbursement systems like the Medicare program usually stress whether certain categories of costs are allowable. This difference is much more important than is commonly realized.

The justifiability and allowability approaches are fundamentally different since they are based on sharply divergent rationales. The allowability approach sees the hospital in absolute terms. Certain types of costs are okay; other types are not okay. In contrast, the justifiability approach sees the hospital in relative terms. The number of nurses seems reasonable in this unit, but cannot fewer be used in that unit?

Since it is easier to employ the allowability approach than the justifiability approach, it is understandable why programs, especially large ones like the Medicare program, have elected to stress the allowability approach. However, the ease with which it can be used does not overcome its fatal flaw: Its underlying assumption is invalid. Large hospital cost savings cannot be obtained by outlawing certain types of costs (unless the effectiveness of hospital care is drastically reduced). Instead, they can only be achieved by judiciously improving the utilization of resources.

The point is clearly illustrated by labor productivity -- one of the major variables through which the Indiana program reduces cost. The problem in the productivity area is not that hospitals are using certain personnel types that they should not be, or that they are instructing their staff to perform tasks that are categorically inappropriate. Instead, the problem is that hospitals have not sufficiently examined and then instituted the multitude of small changes which together will improve labor productivity. Examples of such changes are modifying skill mix in one unit, decreasing personnel in another, and improving working arrangements in a third.

Reliance on the allowability approach thus entails the significant danger that the review program may be lulled to sleep. It may think that it is being a careful watchdog, controlling hospital costs by disallowing certain items. In actuality the reverse may be true. Hospital cost may be escalating at a rapid pace because the program is not significantly impacting the major variables which determine cost. And thus arises the unfortunate paradox of frequent and fretful cost negotiations, while in the background cost inflation continues unabated.

Conflict with Conventional Wisdom. The traditional regulatory model postulates strict separation between the regulator and the regulated industry. It presumes knowledgeability on the part of the regulator, but it eschews past, present, and future relationships between the regulator and the regulated industry, so that it is unclear from whence this knowledgeability comes. It envisions rather formal proceedings where industry and consumers present their cases, with the regulators cross-examining both sides. Upon conclusion of these hearings, the regulators retire to their chambers and eventually reach a decision, which is then handed down to industry and consumers. In short, the traditional model is directly based on the legal system, with a smattering of economics thrown in.

It has never been established that this model works in any industry. For two reasons it is particularly unlikely to succeed in the hospital industry. First, the model is too ponderous; it moves too slowly with too much procedure. It is not geared for the flexible and frequent application of general guidelines to individual cases -- precisely the activity required if costs are to be reduced by improving hospital efficiency. Rather, the traditional model is better adapted to delivering landmark decisions expected to remain in effect for years.

Second, the hospital industry is highly complex. Hospitals use an intricate mixture of labor and nonlabor inputs. Their output is even more complicated. To make matters worse, the whole enterprise is invested with the mystical aura peculiar to healing, sickness, health, life, and death. As a result, it is difficult for a pure consumer to be an effective hospital regulator. At a minimum the regulators in aggregate must have substantial hospital expertise. Further, they must enjoy at least begrudging hospital support. Once hospitals decide to subvert the regulatory system, it will be difficult for the regulators to prevent them from doing so.

From the perspective of hospital regulation there are thus serious defects in the traditional model. First, the model is too rigid and legalistic. Second, there is insufficient provider involvement in the regulatory process. Third, the model is silent on the importance of industry support, but implicitly assumes that such support is unimportant because of the authority vested in the regulators.

To be effective a hospital regulator must correct these defects. If this is done, the resulting revision of the traditional model exhibits characteristics similar to those of the Indiana program. The program's keynote is flexibility. It has not become bogged down in legalistic procedure. It is largely a private sector program, but it features substantial and diverse nonprovider involvement. The program has the solid support of Indiana hospitals, both individually and collectively.

Without question the Indiana system conflicts with the traditional regulatory model and hence with conventional wisdom. However, it represents a model that is much more likely to succeed in the hospital industry. Its success in Indiana and its replicability elsewhere are thus not surprising.

Another important difference, subtle in nature, exists between the Indiana program and the traditional model. The latter is neat. Its lines of authority and procedure are clear-cut, which accounts in part for its rigidity. The former is untidy as are Indiana-type programs in other states. For example: Who appoints the provider members to the RRC? Is it IBC (which has the power on paper) or IHA (which exercises the power in practice)? Or consider the Wisconsin program: Its Rate Review Committee is suspended in space, with approximately equal input from the Blue Cross plan, the hospital association, and the state government.

While perhaps an affront to those who value administrative procedure, this lack of tidiness is a key to the program's success. By its nature an untidy program encourages interchange. It allows negotiation to proceed before positions are hardened. It facilitates the development of compromises which are acceptable to all parties and which all parties are therefore willing to actively support.

Another important property arises from the program's untidiness. According to a program participant:

> Our system rests on the mutual confidence of the players. If this confidence were eroded, we would be dead in the water, and we know it.

It is readily evident to all players that there is nothing in the untidy structure of the Indiana program which ensures this mutual confidence. All players are thus aware that they must work to maintain this confidence. This point may be less obvious in a neat system. It may seem that the tidy structure alone either guarantees or obviates mutual trust. This is false. In a democratic society the effectiveness of all systems -- neat or untidy -- depends in the long run on the mutual confidence of the players. As an Indiana hospital administrator expresses it:

> In our system the relationships are very important. These relationships cannot be legislated. This does not mean that a state program won't work, but it does mean that to work, a state program must strive to create and then maintain the same types of relationships.

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